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DEC 3 1 2014

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555-0001

SUSQUEHANNA STEAM ELECTRIC STATION
LICENSEE EVENT REPORT 50-388(387)/2014-001-00
UNIT 1 LICENSE NO. NPF-14
UNIT 2 LICENSE NO. NPF-22 **Docket Nos. 50-387**
PLA-7270 **and 50-388**

Attached is Licensee Event Report (LER) 50-388(387)/2014-001-00. The LER reports an event involving both doors of a secondary containment airlock being momentarily open resulting in a condition that met the reporting criterion for a condition that could have prevented fulfillment of a safety function.

There were no actual consequences to the health and safety of the public as a result of this event.

This letter contains no new regulatory commitments.

for J. A. Franke

J. A. Franke

Attachment: LER 388(387)/2014-001-00

Copy: NRC Region I
Mr. J. E. Greives, NRC Sr. Resident Inspector
Mr. J. A. Whited, NRC Project Manager
Mr. L. J. Winker, PA DEP/BRP

IE22
NRR

NRC FORM 366 (02-2014) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB: NO. 3150-0104 EXPIRES: 01/31/2017

LICENSEE EVENT REPORT (LER)

(See Page 2 for required number of digits/characters for each block)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
Susquehanna Steam Electric Station, Unit 2	05000388	1 of 3

4. TITLE Both Doors of a Secondary Containment Personnel Airlock Momentarily Open Due to a Personnel Error Resulting in Entry into Secondary Containment Technical Specification Limiting Condition for Operation

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
									Susquehanna Steam Electric Station, Unit 1	05000387
11	05	2014	2014	- 001	00	12	31	2014	FACILITY NAME	DOCKET NUMBER 05000

9. OEPRATING MODE	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check all that apply)*			
1	☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(i)(C)	☐ 50.73(a)(2)(vii)
	☐ 20.2201(d)	☐ 20.2203(a)(3)(ii)	☐ 50.73(a)(2)(ii)(A)	☐ 50.73(a)(2)(viii)(A)
10. POWER LEVEL	☐ 20.2203(a)(1)	☐ 20.2203(a)(4)	☐ 50.73(a)(2)(ii)(B)	☐ 50.73(a)(2)(viii)(B)
	☐ 20.2203(a)(2)(i)	☐ 50.36(c)(1)(i)(A)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(ix)(A)
100	☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)(ii)(A)	☐ 50.73(a)(2)(iv)(A)	☐ 50.73(a)(2)(x)
	☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(v)(A)	☐ 73.71(a)(4)
	☐ 20.2203(a)(2)(iv)	☐ 50.46(a)(3)(ii)	☐ 50.73(a)(2)(v)(B)	☐ 73.71(a)(5)
	☐ 20.2203(a)(2)(v)	☐ 50.73(a)(2)(i)(A)	☒ 50.73(a)(2)(v)(C)	☐ OTHER
	☐ 20.2203(a)(2)(vi)	☐ 50.73(a)(2)(i)(B)	☐ 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

LICENSEE CONTACT	TELEPHONE NUMER *(Include Area Code)*
C. E. Manges, Jr., Senior Engineer – Nuclear Regulatory Affairs	570 542 3089

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
☐ YES *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☒ NO				

ABSTRACT *(Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)*

On November 5, 2014 at 1115 hours, Secondary Containment Zone 3 (Unit 1 & 2 Reactor Building) was unintentionally cross tied to Secondary Containment Zone 2 (Unit 2 Reactor Building) for several seconds during passage of personnel through a personnel airlock. Secondary Containment Zone 2 and Zone 3 ventilation remained in service and stable. Limiting Condition for Operation (LCO) 3.6.4.1 was entered and exited based on the prohibited crosstie of Secondary Containment Zones. This event was reported under 10 CFR 50.72(b)(3)(v)(C) as a loss of a safety function. There is no redundant Susquehanna Secondary Containment System.

The cause of the event was a human performance error in that a self-check was not performed prior to opening the airlock door. The individual was coached on the importance of self-check for verifying conditions are met prior to passage through a Secondary Containment airlock door. A communication to all station personnel will be distributed reinforcing the significance of secondary containment airlocks, the conditions required for passage through an airlock, and how to verify these conditions.

There were no actual consequences to the health and safety of the public as a result of this event.

NARRATIVE

CONDITIONS PRIOR TO EVENT

Unit 1 – Mode 1, 100 percent Rated Thermal Power

Unit 2 – Mode 1, 100 percent Rated Thermal Power

There were no structures, systems, or components that were inoperable at the start of the event that contributed to the event.

EVENT DESCRIPTION

On November 5, 2014 at 1115 hours, Secondary Containment Zone 3 (Unit 1 & 2 Reactor Building [EIIS System Identifier: NG]) was unintentionally cross tied to Secondary Containment Zone 2 (Unit 2 Reactor Building) for approximately two seconds during passage of personnel through a personnel airlock [EIIS Component Identifier: AL]. Secondary Containment Zone 2 and Zone 3 ventilation [EIIS System Identifier: VA] remained in service and stable.

Limiting Condition for Operation (LCO) 3.6.4.1 was entered and exited based on the prohibited crosstie of Secondary Containment Zones. Technical Specification Secondary Containment Operability requires that at least one door [EIIS Component Identifier: DR] remain closed for airlocks where two doors are provided when an access opening between Secondary Containment Zones is being used for exit and entry.

This event was reported under 10 CFR 50.72(b)(3)(v)(C) and per the guidance of NUREG 1022, Revision 3, Section 3.2.7 as a loss of a safety function (EN 50595). There is no redundant Susquehanna Secondary Containment System.

Details of the investigation of the event are as follows:

A Non-Licensed Operator (NLO) was performing equipment checks in the Unit 2 Reactor Building. Following completion of the equipment checks, the NLO approached Door DR-115R to egress through Airlock II-606. The NLO unlatched Door DR-115R prior to verifying the airlock was clear and that conditions were met for opening the door. During an interview, the NLO stated that at the moment he unlatched the door, he noticed the red light [EIIS Component Identifier: IL] was illuminated, indicating the opposite airlock door was not latched and conditions were not met for passage through Door DR-115R. The NLO immediately reclosed and latched Door DR-115R, restoring the airlock and separation of Secondary Containment Zones 2 and 3. After reclosing and latching Door DR-115R, the NLO confirmed that personnel passed through the airlock and had not yet closed and latched the opposite door at the time he unlatched door DR-115R. The NLO immediately notified the Control Room and submitted a condition report to document the event.

The NLO stated that he did not focus on verifying airlock conditions prior to unlatching Door DR-115R.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
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NARRATIVE

CAUSE OF EVENT

The cause of the event was human performance error in that a self-check was not performed prior to opening the airlock door.

ANALYSIS/SAFETY SIGNIFICANCE

The actual consequence was inadvertent, prohibited crosstie of Secondary Containment Zones 2 and 3 requiring momentary entry into LCO 3.6.4.1 and an eight hour notification of the event to the Nuclear Regulatory Commission (NRC).

An engineering evaluation was performed and concluded that secondary containment could have performed its safety function of isolating as assumed in the accident analysis and also of re-establishing 0.25 inches vacuum (drawdown) within the assumed accident analysis time (10 minutes). Therefore, the subject event did not cause a loss of safety function. This event will not be counted as a safety system functional failure (SSFF) for the NRC performance indicator based on the engineering analysis that shows there was no loss of ability to fulfill the safety function.

CORRECTIVE ACTIONS

The on-shift Shift Manager coached the NLO on the importance of self-check for verifying conditions are met prior to passage through a Secondary Containment airlock door.

A communication to all station personnel will be distributed reinforcing the significance of secondary containment airlocks, the conditions required for passage through an airlock, and how to verify these conditions. The communication will also highlight the need for personnel to verify that the opposite door is closed first and, if possible, locked in position before entering or exiting a personnel airlock (PAL).

PREVIOUS SIMILAR EVENTS

No previous similar events were identified.